

Evidence for addition of age & birth date is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(B10)*

## CERTIFICATE OF DEATH

*02707*

Reg. Dist. No. *63*

FILM NO. G 94 MAY 11 1945

### 1. PLACE OF DEATH:

County

*Caroline*

City or town

*Denton* *Tid.*

(If outside city or town limits, write RURAL and give nearest town)

*Rural*

How long in above place of death?

*25 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

*John H. Baggs.*

4. Sex

*M*

5. Color of face

*so.*

6. (a) Single, married, widowed, or divorced

*married*

6. (b) Name of husband or wife

*Minnie Lucas Baggs.*

6. (c) If alive, give age years

*December 20, 1858*

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

*85*

*3*

*2*

hrs.

min.

9. Birthplace

*Near Greenbush Tid.*

(Town, county, and state)

10. Usual occupation

*Retired*

11. Industry or business

**MOTHER**

12. Name

*Andrew Baggs*

13. Birthplace

*Maryland*

14. Maiden name

15. Birthplace

16. Informant

*Mr. John H. Baggs*

Address

*Denton*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *3-25-45*  
(month) (day) (year)

Cemetery or cemetery

*Denton Cemetery*

Location

*Denton Tid.*

18. Funeral director

*J. Virgil Morris*

Address

*Denton Tid.*

19. *3/24*

*1945*

(Date rec'd by registrar)

*Marie George*

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Caroline*

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

2D. DATE OF DEATH *Mar 22* *1945* at *9A*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*May 1942* to *Mar 22 1945*

and that I last saw him alive on *Mar 22 1945*

Immediate cause of death

Due to *Cardio Renal - vascular disease*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

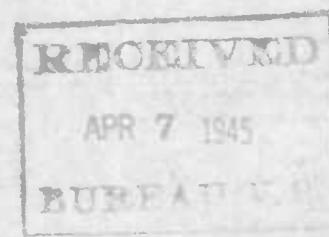
Means of injury

Injured at work?

23. SIGNATURE

*Lawson T. George* M. D. or other

Address *Denton* Date signed *3/24/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

02708

## CERTIFICATE OF DEATH

Reg. Dist. No. 6-6

## 1. PLACE OF DEATH:

County..... Caroline

City or town..... Ridgely Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 10 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Charlotte Brooks

4. Sex

F.

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife.....

William H. Brooks

7. Birth date of deceased (mo., day, yr.)

April 10 - 1872

8. (c) If alive, give age..... 80 years

8. AGE: Years

72

10

Months

9

Days

If less than one day  
hrs. .... min.

9. Birthplace.....

Concord Pa.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

Absent Nurse

FATHER

12. Name.....

Absent Nurse

MOTHER

13. Birthplace

N. J.

14. Maiden name.....

Susie Meyers

15. Birthplace

N. J.

16. Informant.....

William H. Brooks

Address

Ridgely Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof. March 12/44  
(month) (day) (year)

Cemetery or crematory.....

West Denton

Location.....

Denton Md.

18. Funeral director.....

Raymond B. Rawlings

Address

Lancaster Md.

19. Mort. 23 1945  
(Date rec'd by registrar)

at St. Louis

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County..... Caroline

City or town..... Ridgely Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 19 1945 at 10:38 AM

I CERTIFY that death occurred on the date above stated; the attended deceased from

Dec. 6 1944 Mar. 19 1945

and that I last saw him alive on March 19 1945

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

1 day

Due to.....

Hypertensive-Cardiac -  
cereb. renal disease

1 year

Due to.....

Influenza Dec. 6-44

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

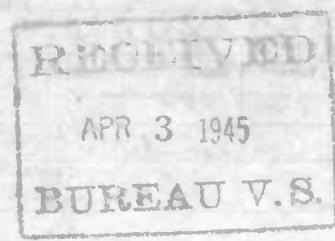
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Denton, Md. Date signed..... 3-20-45



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57-6

02709

## CERTIFICATE OF DEATH

Reg. Dist. No. 103

## 1. PLACE OF DEATH:

County CarolineCity or town Preston - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49 years

Hospital, Institution, or street address where death occurred:

Near Farngard

How long in hospital or institution?

## 3. (a) FULL NAME

Harry J. Burklew

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Mettie V. Burklew

## 7. Birth date of deceased (mo. day, yr.)

December 24 18836. (c) If alive, give age 49 years

## 8. AGE:

Years  
61Months  
2Days  
7If less than one day  
.....hrs. ....min.

## 9. Birthplace

Cumberland Maryland

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

Farm

## FATHER

12. Name David Burklew

## MOTHER

13. Birthplace Allegany County, Maryland

## 14. Maiden name

Martha Trelman

## 15. Birthplace

Allegany County, Maryland

## 16. Informant

Mrs. Mettie V. Burklew

## Address

Preston, Maryland, R.F.D.

## 17. Burial

Date thereof March 5 1945  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)

## Cemetery or crematory

Linchester Cemetery

## Location

Near Preston, Maryland

## 18. Funeral director

J.J. Trampton & Son

## Address

Federalsburg, Maryland

## 19. Date rec'd by registrar

March 3 1945

(Date rec'd by registrar)

C.W. Plummer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarolineCity or town Preston - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Farngard

(If rural give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 1945 to March 1 1945and that I last saw him alive on March 1 1945Immediate cause of death Cardiac Failure due to Inflammation

DURATION

Due to Carcinoma of Prostate

6 mo.

Due to

Other conditions Chronic Tubercular Disease

?

Cirrhosis of Liver

?

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

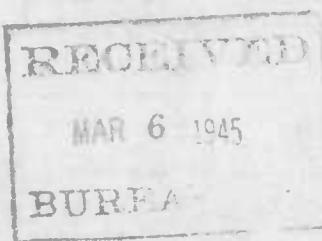
Means of Injury

Injured at work?

23. SIGNATURE July B. Plummer

M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

02710  
Reg. Dist. No. 62

1. PLACE OF DEATH: Caroline Denton  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, Institution, or street address where death occurred:  
Court Square  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....Maryland County.....Caroline  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....Court Square  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME James Norman Clark  
 4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 B.(b) Name of husband or wife Alma Thompson Clark  
 7. Birth date of deceased (mo., day, yr.) November 2, 1892 6.(c) If alive, give age 50 years  
 8. AGE: Years 52 Months 4 Days 20 If less than one day  
 . hrs. ..... min.  
 9. Birthplace Caroline Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Hardware Merchant - Farmer  
 11. Industry or business  
 MOTHER FATHER 12. Name James Mr. Clark  
 13. Birthplace Caroline Co., Maryland  
 14. Maiden name Dora G. Towers  
 15. Birthplace Caroline Co., Maryland  
 18. Informant Daughter Mrs. Norman Clark  
 Address Denton  
 17. Burial Burial Date thereof 3-26-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Sorenson Cemetery  
 Location Tidebrook Rd.  
 18. Funeral director J. Siegel Funeral Home  
 Address Denton Rd.  
 19. Date rec'd by registrar 3-24-45 M.D. or other Ridgely Md.  
 (Date rec'd by registrar) Registrar Date signed 3-24-45

3. (b) Social Security Number /

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945 at 4:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25 1939 to March 22 1945 and that I last saw him alive on March 22 1945Immediate cause of death Cerebral embolus - E. hemiplegia DURATION left 3-20-45Due to Endocarditis - vegetative 1 year or more  
Pulmonary embolus & Effusion Feb 1945Due to Coronary thrombosis Anterior Apr 1943Coronary arteritis anterior 7 days or moreOther conditions Vertebrobasilar, atherosclerosis Feb 1945Diabetes mellitus 1 year or moreMajor findings of operations none Data of op. \_\_\_\_\_Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

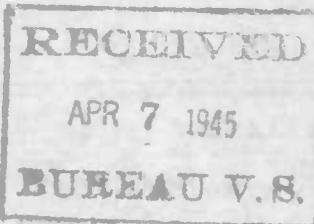
Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE J. Siegel MD. M. D. or other Ridgely Md.Address 3-24-45 Date signed 3-24-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH  
residence of deceased is shown on 2411 N. Charles St., Baltimore 51B  
FILM NO. G 94 MAY 15 1945

02711

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County.....

Caroline

City or town.....

Denton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

39 yrs.

Hospital, Institution, or street address where death occurred:

7th Street

How long in hospital or institution?.....

~

## 3. (a) FULL NAME

Fred E. Covey

4. Sex

m.

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife.....

Georgia A. Covey

So

years

7. Birth date of deceased (mo., day, yr.)

November 16, 1877

8. (c) If alive, give age

8. AGE:

Years  
67Months  
4Days  
14

If less than one day

hrs. .... min.

9. Birthplace.....

Hyson, Md.

(Town, county, and state)

10. Usual occupation.....

office work

11. Industry or business

former County treasurer

12. Name.....

Andrew Covey

13. Birthplace

Md.

14. Maiden name.....

Sarah Hubbard

15. Birthplace

Md.

16. Informant.....

Mrs. Fred Covey

Address

Denton, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... April 3, 1945  
(month) (day) (year)

Cemetery or crematory.....

Greensboro Cemetery

Location.....

Greensboro, Md.

18. Funeral director.....

Harvey Williamson

Address

Federalburg, Md.

19. 3-5

18. K.S.

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Caroline

City or town.....

Denton

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

7th Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

no

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 31

1945

at 8 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

October 8, 1944, to March 31, 1945

and that I last saw him alive on March 30, 1945

Immediate cause of death.....

Carcinoma of Prostate  
with metastases to  
the lower spine & hip

DURATION

2 yrs

Due to.....

See lower spine &amp; hip

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Charles W. Stonerfield, M.D.

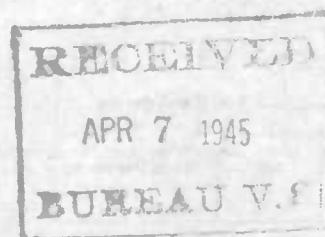
M. D. or other

Address.....

Greensboro, Md.

Date signed.....

4/2/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

## CERTIFICATE OF DEATH

02712

Reg. Diet. No. 62

1. PLACE OF DEATH:  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
*George Walter Densmore*

4. Sex *m* 5. Color or race *W. African*  
 (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife *Eugenia Scott Densmore*

7. Birth date of deceased (mo., day, yr.) *Mar. 25<sup>th</sup> 1869*

8. AGE: Years *76* Months *6* Days *It less than one day* hrs. *min.*

9. Birthplace *Hillsboro, Ind.*  
 (Town, county, and state)

10. Usual occupation *retired farmer*

11. Industry or business

12. Name *George Densmore*

13. Birthplace *Maryland*

MOTHER FATHER

14. Maiden name *Susan Spencer*

15. Birthplace *Deerton Ind.*

16. Informant *Mrs Clifton Calfee*

Address *Deerton Ind.*

17. Buried *Buried* Date thereof *4-3-45*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Deerton Cemetery*

Location *Deerton Ind.*

18. Funeral director *J. Sigel Funeral Home*

Address *Deerton Ind.*

19. 4 - 3 1945 Date rec'd by registrar *Frank O. George*  
 (Date rec'd by registrar) Registrar *Frank O. George*

3. (b) Social Security Number

## MEDICAL CERTIFICATION

1. DATE OF DEATH *March 31 1945* at *10P*  
 I certify that death occurred on the date above stated; that I attended deceased from  
*April 19. 45* to *Mar 31 1945*  
 and that I last saw him alive on *Mar 31 1945*

Immediate cause of death *Cardio-Vascular - Renal*  
 Due to *disease* Duration *3 yrs -*

Due to

Other conditions

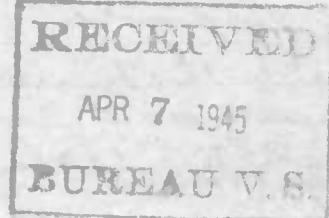
(Include pregnancy within 8 months of death)

Major findings of operations  Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE *Lawson D. George* M. D. or other   
 Address *Deerton Ind.* Date signed *4/3/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

02713

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County CarolineCity or town New Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex F 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife Eelia Feyer7. Birth date of deceased (mo., day, yr.) Jan. 25<sup>th</sup> 18706.(c) If alive, give age years8. AGE: Years 75 Months 1 Days 17 If less than one day hrs. min.9. Birthplace Patterson Penn.  
(Town, county and state)10. Usual occupation at home11. Industry or business not knownFATHER 12. Name Francesca Bush13. Birthplace Penn.MOTHER 14. Maiden name Francesca Bush15. Birthplace Penn.16. Informant Mrs. Mary DengerAddress Rd. 1 New Berlin Ind.17. (Burial, cremation, or removal. Which?) Buried Date thereof 3-15-45  
(month) (day) (year)Cemetery or crematory Ogallala Memorial ParkLocation Patterson Pa18. Funeral director J. E. Engel Record Co.Address New Berlin Ind.19. 3-14 1945 Mar 08 Denger  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind.County CarolineCity or town New Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) if veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12<sup>th</sup> 1945 at 3 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Jan 12 1945 and that I last saw her alive on Jan 12 1945

Immediate cause of death

Due to Chronic Myocarditis Duration 2 yrs.

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

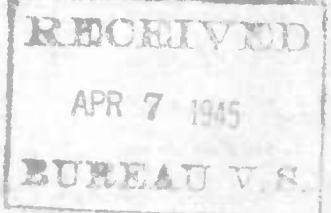
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

33. SIGNATURE Alison D. George

M. D. or other

Address New Berlin Ind. Date signed 3/14/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

02714

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County.....

City or town.....

*Cards fine  
near Denton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *25 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*mr**mr.**Married*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

*Febr. 7<sup>th</sup> 1855*

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

*Penn.*

10. Usual occupation

*Pitiful Farmer*

11. Industry or business

*Henry Seisel*

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

*3-18-45*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

*Denton Cemetery**Denton Aug. 1**J. Siegel Mason**J. Deegan Eng.**3-17 1945*

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug. 15<sup>th</sup> 1945*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*August 21 1945*and that I last saw him alive on *March 13 1945*

Immediate cause of death.....

*Coronary arteritis &clerosis*

DURATION

*6 hrs.*

Due to.....

Due to.....

Other conditions *General arteritis & sclerosis*

6 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

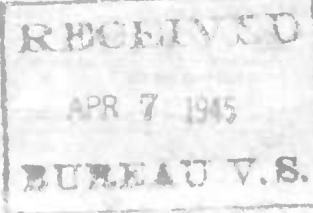
Injured at work?

23. SIGNATURE.....

*S. Paul Knott M.D.*

M. D. or other

Address..... Date signed..... *3/17/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

02715

## CERTIFICATE OF DEATH

Reg. Dist. No... 61

## 1. PLACE OF DEATH:

County CarolineCity or town Grasonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Wilhelmina P. Godwin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.W.Wedded

6. (b) Name of husband or wife

George W. Godwin

7. Birth date of deceased (mo., day, yr.)

March 3, 1855

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
89	11	28	hrs. min.

9. Birthplace

Kent County, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden name

Unknown

15. Birthplace

16. Informant

Walter Garey

Address

Easton Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 5, 1945  
(month) (day) (year)

Cemetery or crematory

Spring Hill

Location

Bethel Md.

18. Funeral director

Charles Clark

Address

Easton Md.19. 3/519. 4520. 7-11-45

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Caroline

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 1, 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1, 1945 to March 1, 1945and that I last saw her alive on March 1, 1945

Immediate cause of death

Arteriosclerosis  
Cardiovascular Disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles H. Hooper, M.D.

M. D. or other

Address

Greencastle, Pa.

Date signed

1945

PLEASE WRITE PLAINLY, WITH UNFADING INK, Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

02716

## CERTIFICATE OF DEATH

Reg. Dist. No. 66

## 1. PLACE OF DEATH:

County.....

City or town.....

Caroline  
Ridgely

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

24 hr

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Rodgers Henry Hall

4. Sex

5. Color of race

6.(a) Single, married, widowed, or divorced

Male

white

single

D.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

March 29, 1945

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

it less than one day

7 hrs. 15 min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER

12. Name.....

Thomas Henry Hall

13. Birthplace

Denton, Maryland

MOTHER

14. Maiden name.....

Mary Emma Cole

15. Birthplace

Ridgely, Md.

16. Informant.....

Lucy Emma Hall

Address

Ridgely 2nd

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof. March 30 / 1945  
(month) (day) (year)

Cemetery or crematory.....

Garrison

Location.....

Garrison 2nd

18. Funeral director.....

Raymond B Rawlings

Address

Garrison 2nd

19. March 30, 1945

(Date rec'd by registrar)

J. A. Davis

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Ridgely (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 29 1945 at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 29 1945 to 1945

and that I last saw him alive on March 29 1945

Immediate cause of death.....

Prematurity

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

none

Date of op.

Autopsy results.....

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

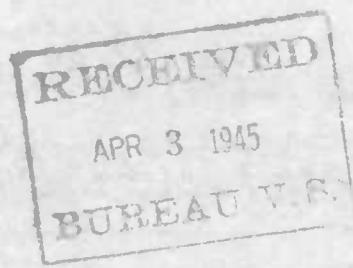
Injured at work?

23. SIGNATURE.....

J. A. Davis MD.

M. D. or other

Address..... Ridgely, Md. Date signed..... March 29, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

## CERTIFICATE OF DEATH

02717 62  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County CarolineCity or town Denton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME:

H. Clay Hobbs.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M.W.Widower6.(b) Name of husband or wife Evelyn Harry Hobbs.

7. Birth date of deceased (mo., day, yr.)

Oct. 17, 1888

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

86427

hrs. min.

9. Birthplace

Hobbs, Caroline, Maryland

(Town, county, and state)

10. Usual occupation

Canner

11. Industry or business

Starchbury Hobbs.

FATHER

MOTHER

12. Name Delaware

FATHER

MOTHER

13. Birthplace

Eleanor Johnson

FATHER

MOTHER

FATHER

14. Maiden name

Delaware

FATHER

MOTHER

FATHER

FATHER

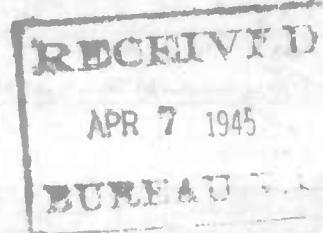
15. Birthplace

Del.

FATHER

MOTHER

FATHER



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

02718

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County CarolineCity or town Federalsburg

(If outside city or town limits, write RURAL and give nearest town)

25 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

Greenridge Road

How long in hospital or institution?

## 3. (a) FULL NAME

Eseneth F. Jones

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

B. (b) Name of husband or wife

Noah N. Jones

7. Birth date of deceased (mo., day, yr.)

August 8, 1846

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

98

7

15

...hrs. ....min.

9. Birthplace

Dorchester County, Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Home

MOTHER

FATHER

12. Name

Samuel A. Williams

13. Birthplace

Dorchester County, Maryland

14. Maiden name

Jamya Adams

15. Birthplace

Caroline County, Maryland

16. Informant

Mrs. Lydia A. Pusey

Address

Federalsburg, Maryland

17. Burial

Date thereof March 26, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hill Crest Cemetery

Location

Federalsburg, Maryland

18. Funeral director

J. J. Frampton & Son

Address

Federalsburg, Maryland

19. March 24 1945

J. J. Frampton

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarolineCity or town Federalsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Greenridge Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 23 1945 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 1, 1945 to Mar 23, 1945, and that I last saw her alive on Mar 23, 1945.

Immediate cause of death

Chronic myocarditis  
Senility

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

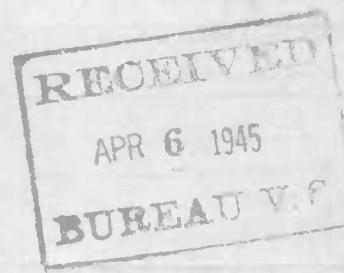
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank M. Anderson Jr.  
M. D. or other  
Address Federalsburg, Md. Date signed March 23, 1945



Evidence for change of  
year of birth is shown on

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

62719

## CERTIFICATE OF DEATH

Reg. Dist. No. 66

FILM NO. G 94 MAY 11 1945

## 1. PLACE OF DEATH:

County.....

City or town.....

Caroline

Ridgeley, W. Va.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, institution, or street address where death occurred.....

How long in hospital or institution?

## 3. (a) FULL NAME

Julia Kelcey.

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed.

8. (b) Name of husband or wife.....

John Kelcey.

7. Birth date of deceased (mo., day, yr.)

May 1 - 1873 1871

8. (c) If alive, give age years

8. AGE:

Years  
73Months  
10Days  
14If less than one day  
hrs. min.

9. Birthplace.....

Austria Hungary.

(Town, county, and state)

10. Usual occupation.....

Housewife.

11. Industry or business

✓

MOTHER FATHER

12. Name.....

Unknown

MOTHER FATHER

13. Birthplace

Austria Hungary

MOTHER FATHER

14. Maiden name

Mary

MOTHER FATHER

15. Birthplace

Austria Hungary

MOTHER FATHER

16. Informant

Mrs Julia Keltch

MOTHER FATHER

Address

Ridgeley W. Va.

MOTHER FATHER

17. Burial

Date thereof Med. 17. 46-

MOTHER FATHER

(Burial, cremation, or removal. Which?)

(month) (day) (year)

MOTHER FATHER

Cemetery or crematory

Honey Cross.

MOTHER FATHER

Location

Denton Lumbrook Rd.

MOTHER FATHER

18. Funeral director

Raymond B. Pavewigs

MOTHER FATHER

Address

Lumbrook Rd.

MOTHER FATHER

19. Date rec'd by registrar

Mar 17 1945

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

Caroline

City or town Ridgeley, W. Va.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar. 15-

19 46 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 8 1943 to March 15 1946

and that I last saw her alive on Mar. 17 1946

Immediate cause of death cerebral hemorrhage DURATION 1 day

Due to. Atherosclerosis

Due to.

Other conditions

(Include pregnancy within 6 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

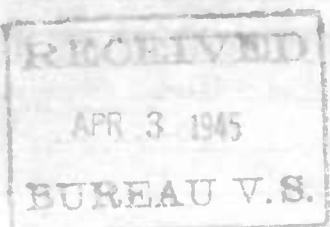
Kurt Ledder M.D.

M. D. or other

Address

West Anne St.

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Subsequent every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
year of birth of deceased MARYLAND STATE DEPARTMENT OF HEALTH  
is shown on

2411 N. Charles St., Baltimore 932

02720

FILM NO. G 94 MAY 16 1945

# CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH: Caroline  
 County: Greensboro  
 City or town: Greensboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

3. (a) FULL NAME Clementine Nichols

4. Sex f 5. Color or race w 6.(a) Single, married, widowed, or divorced Widowed.

6.(b) Name of husband or wife George Nichols.

7. Birth date of deceased (mo., day, yr.) March 18 - 1878 1868 8. (c) If alive, give age years

8. AGE: Years 77 Months  Days 7 If less than one day  hrs.  min.

9. Birthplace Greensboro Md.  
 (Town, county, and state)

10. Usual occupation Housing.

11. Industry or business William Nichols.

MOTHER FATHER 12. Name William Nichols.

13. Birthplace Md.

14. Maiden name Sarah Porter

15. Birthplace Md.

16. Informant Earl Nichols.

Address Sedley-ville Del.

Burial Greensboro Date thereof Mar 29 / 45 -

(Burial, cremation, or removal, which?) Greensboro (month) (day) (year)

Cemetery or crematory Greensboro

Location Greensboro Md.

18. Funeral director Raymond B. Rawlings

Address Greensboro Md.

19. Date rec'd by registrar Mar 29 1945 S. McPhee

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: Md. County: Caroline  
 City or town: Greensboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.:  
 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1, 1945 to Mar. 16, 1945

and that I last saw her alive on March 26, 1945

Immediate cause of death Chronic Myocarditis DURATION

Due to:

Due to:

Other conditions Arterio Bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D W. Thompson Md. M. D. or other

Address Greensboro Md. Date signed 3/29/45

RECEIVED

APR 5 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13A

02721

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County CarolineCity or town Federalburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LifeHospital, institution, or street address where death occurred: Concord

How long in hospital or institution?

## 3. (a) FULL NAME

Jacob Nichols4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Katie Nichols7. Birth date of deceased (mo., day, yr.) July 26, 1866 8. (c) If alive, give age 74 years8. AGE: Years 78 Months 8 Days 5 If less than one day ..... hrs. ..... min.9. Birthplace Caroline County, Maryland  
(Town, county, and state)10. Usual occupation Retired Blacksmith11. Industry or business Blacksmith12. Name Robert J. Nichols13. Birthplace Caroline County, Maryland14. Maiden name Lelia C. Wareh15. Birthplace Caroline County, Maryland16. Informant Mrs. Katie NicholsAddress Federalburg, Maryland, R.F.D.17. Burial Burial Date thereof April 2, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest CemeteryLocation Federalburg, Maryland18. Funeral director J. J. Frampton and SonAddress Federalburg, Maryland19. Date rec'd by registrar April 2, 1945

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Federalburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Concord

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1945 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Cat 1944 to March 31, 1945

and that I last saw h..... alive on .....

Immediate cause of death.....

DURATION

Due to Cystic Vascular  
Renal Disease

62 mos

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

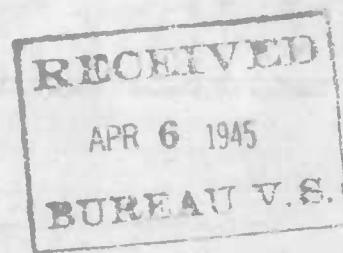
Means of injury.....

Injured at work?

23. SIGNATURE Wilson D. Tracy

M. D. or other

Address Denton Date signed 4/2/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

02722

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

## 1. PLACE OF DEATH:

County..... *Caroline*  
 City or town..... *Greenbush Rural*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *11 years*.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

*Thomas A. Schlegel.*

## 3. (b) Social Security Number

## 4. Sex

*m*

## 5. Color or race

*w*

## 6. (a) Single, married, widowed, or divorced

*Married.*

## 6. (b) Name of husband or wife

*Mary A. Schlegel.*B. (c) If alive, give age..... *64* years

## 7. Birth date of deceased (mo., day, yr.)

*Oct 9. 1865-*

## 8. AGE:

Years  
*79*Months  
*5-*Days  
*11*It less than one day  
..... hrs. .... min.

## 9. Birthplace

*Nashawango County Pa.*

(Town, county, and state)

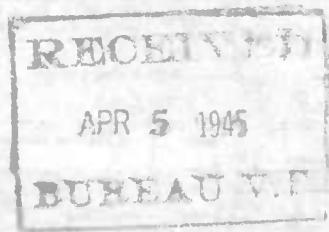
## 10. Usual occupation

*Fanner*

## 11. Industry or business

*✓*

## MOTHER FATHER



**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-A

02723

## **CERTIFICATE OF DEATH**

Reg. Dist. No. 67

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death?..... Hospital, institution, or street address where death occurred: <i>Steward Nursing Home</i>			Street No. .... (If rural, give LOCATION)		
How long in hospital or institution?..... 2 years			2.(a) If veteran, name war.....		
3. (a) FULL NAME <i>Sallie Schmidt</i>			3. (b) Social Security Number		
4. Sex <i>F</i>	5. Color or race <i>W.</i>	6.(a) Single, married, widowed, or divorced <i>Widowed.</i>	MEDICAL CERTIFICATION		
6.(b) Name of husband or wife..... <i>August Schmidt</i>			20. DATE OF DEATH..... <i>March 31 1945</i>		
7. Birth date of deceased (mo., day, yr.) <i>March 1. 1865</i>			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>March 22 1945</i> to <i>Mar. 31 1945</i> and that I last saw her alive on <i>March 30 1945</i>		
8. AGE: Years <i>80</i>			Immediate cause of death..... <i>Arteriosclerosis Cardis - Vascular Disease</i>		
Months <i>1</i>			DURATION		
Days <i>30</i>					
If less than one day hrs. .... min.					
9. Birthplace..... (Town, county, and state) <i>Baltimore Md.</i>					
10. Usual occupation..... <i>Retired</i>					
11. Industry or business..... <i>No Record</i>					
12. Name..... <i>Germany</i>					
13. Birthplace..... <i>Germany</i>					
14. Maiden name..... <i>No Record</i>					
15. Birthplace..... <i>Germany</i>					
16. Informant..... <i>Steward Nursing Home</i>					
Address..... <i>Greensboro N.C.</i>					
17. Burial..... (Burial, cremation, or removal) Which?..... <i>Burial</i>			Date thereof..... (month) (day) (year) <i>April 21 1945</i>		
Cemetery or crematory..... <i>Greensboro N.C.</i>			Accident, suicide, or homicide..... <i>Accident</i>		
Location..... <i>Greensboro N.C.</i>			Where did injury occur?..... <i>Steward Home, Greensboro N.C.</i>		
18. Funeral director..... <i>Raymond B. Rawlings</i>			Injured at home, farm, industry, public place (where?) <i>In Nursing home</i>		
Address..... <i>Greensboro N.C.</i>			Means of injury..... <i>Injured at work?</i>		
19. Date rec'd by registrar..... <i>Mar. 31 1945 - L. McPhee</i>			Signature..... <i>Clark H. Hansen N.C.</i>		
Registrar..... <i>M. D. Price</i>			Address..... <i>Greensboro N.C.</i>		

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APR 5 1945

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

102724  
Reg. Dist. No. 27

## 1. PLACE OF DEATH:

County.....

Caroline

City or town.....

Greensboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

John Schwelius

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

married

B. (b) Name of husband or wife.....

Bertha Schwelius

7. Birth date of deceased (mo., day, yr.)

Aug 4, 18 1877

B. (c) If alive, give age 64 years

8. AGE:

Years  
67Months  
7Days  
10

If less than one day

hrs.

min.

9. Birthplace.....

Fellow's Mill,

(Town, county, and state)

Farmers

10. Usual occupation.....

11. Industry or business

Philip Schwelius

FATHER

12. Name.....

Germany

MOTHER

13. Birthplace

Katherine Schmidt

14. Maiden name.....

Germany

15. Birthplace

Germany

16. Informant.....

Mrs. Bertha Schwelius

Address

Greensboro Md.

17. Burial, cremation, or removal (which?)

Burial

Date thereof Aug 1, 1945

(month) (day) (year)

Cemetery or crematory

Greensboro

Location

Greensboro Md.

18. Funeral director.....

Raymond B. Rawlings

Address

Greensboro Md.

19. Date rec'd by registrar

May 31, 1945, L. MacLay

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Caroline

City or town.....

Greensboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar. 28

19 48 at 10:21 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 4 1948 to Mar 28 1948 and that I last saw him alive on March 27 1948

Immediate cause of death.....

Cerebral Hemorrhage.

DURATION

Due to.....

General debility.

1

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury

Injured at work?

23. SIGNATURE

J. J. Clegg

M. D. or other

Address.....

Harrington Dr.

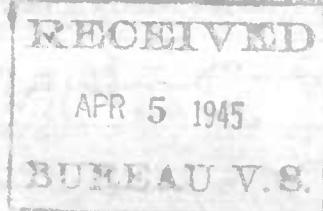
Date signed

8/20/48

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SOCIETY OF THE STATE OF NEW YORK

IN CASE NO. 27 ADMITTED

TO THE LIBRARY OF THE STATE CHARTERED SOCIETY



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02725

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

## 1. PLACE OF DEATH:

County.....

Caroline

City or town.....

Pensacola Pens.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

50 years.

Hospital, Institution, or street address where death occurred.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mary A. Sippel

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed.

6.(b) Name of husband or wife.....

William B. Sippel.

7. Birth date of

deceased (mo., day, yr.)

Mech. 6 - 1870

8. (c) If alive, give age

years

8. AGE:

Years  
75

Months

Days  
8

If less than one day

hrs. min.

9. Birthplace.....

Pennsylvania.

(Town, county, and state)

10. Usual occupation.....

Housewife.

11. Industry or business

MOTHER FATHER

12. Name.....

Henry Foshworth

13. Birthplace

Pensacola

14. Maiden name.....

Vickiowicz

15. Birthplace

Pennsylvania.

16. Informant.....

Noble Sippel

Address

Pensacola Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 12, 46-

(month) (day) (year)

Cemetery or crematory.....

Pensacola

Location.....

Pensacola Md.

16. Funeral director.....

Paymond B. Paulings

Address

Pensacola Md.

19. Med. 102

1945 L. M. Sippel

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Caroline

City or town.....

Pensacola Pens.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 9 1945 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 1, 1944 to Mar. 9, 1945

and that I last saw her alive on Mar. 9, 1945

Immediate cause of death.....

Myocarditis

DURATION

Due to.....

Chronic Bronchitis

Due to.....

Pul. Disease

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

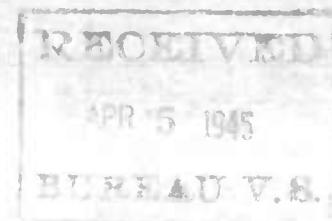
Charles H. Householder, M.D.

G. D. 100

10

Address..... Date signed.....

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APR 10 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 302

02726

## CERTIFICATE OF DEATH

Reg. Dist. No. 66

## 1. PLACE OF DEATH:

County.....*Caroline*City or town.....*Ridgely* - Rural

(If outside city or town limits, write RURAL and give nearest town)

*20 yrs*

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Charles Henry Smith*4. Sex *Male* 5. Color or race *Colored* 6.(a) Single, married, widowed, or divorced *Single*

6.(b) Name of husband or wife.....

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) *Nov. 2 1901*8. AGE: Years *43* Months *4* Days *12* If less than one day  
hrs. ..... min.9. Birthplace.....*Talbot Co., Md.*  
(Town, county, and state)10. Usual occupation.....*Clover*11. Industry or business.....*Farming*12. Name.....*Alex Smith*13. Birthplace.....*Md*14. Maiden name.....*Emma Prattis*15. Birthplace.....*Md*16. Informant.....*Virginia Bailey*Address.....*Ridgely, Md.*  
17. Burial.....*Burial* Date thereof.....*3-17-45*  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory.....*Spring Grove Cemetery*Location.....*Neas Denton*18. Funeral director.....*J. Virgil Moore*Address.....*Denton Md*19. Date rec'd by registrar.....*May 16 1945* Registrar.....*Ed Davis*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Caroline*City or town.....*Ridgely* - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 14 1945* at *6 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *December 20 1944* to *March 7 1945* and that I last saw him alive on *March 7 1945*

Immediate cause of death.....

*Pulmonary Tuberculosis* DURATION  
Due to.....*Syphilitic* *3 mo in more years*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....*J. J. Moore MD*

M. D. or other

Address.....*Ridgely Md* Date signed.....*3-14-45*

